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AUTHOR Cook, Barbara J.
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ABSTRACT

This document addresses the problems faced by families with a schizophrenic member, based on a survey of the literature from a variety of sources including: (1) the Alden Library of Ohio University; (2) the ERIC database; (3) the American Association of Counseling and Development (AACD); and (4) the National Alliance for the Mentally Ill (NAMI). Chapter 1 introduces the topic, states the problem under study, and describes the need and purpose for the study. Included in this chapter are definitions of terms, questions for research, and statement of limitations. Chapter 2 comprises a review of the literature on schizophrenia and the family. Chapter 3 discusses and analyzes the literature reviewed, first focusing on research into the biological and environmental causes of schizophrenia, and next discussing obstacles encountered by families with schizophrenic members, coping strategies for such families, treatment options for families, and counselor variables that influence treatment. Chapter 4 summarizes the findings and answers the specific research questions relating to dysfunctional practices of families with a schizophrenic member. Questions concern such issues as obstacles encountered by families with schizophrenic members, guidelines to foster maximum family growth, programs that develop and nurture optimal growth in families with a schizophrenic member, and counselor variables that address these problems. (TE)

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Schizophrenia and the Family

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Barbara J. Cook

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Director,

School of Applied Behavioral Sciences

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CHAPTER ONE

Introduction

Schizophrenia is to psychiatry what cancer is to medicine: a sentence as well as a diagnosis (Andrews, Goldstein, 1985). Schizophrenia has been called one of the most sinister words in the language. It evokes visions of madness and asylums.

People with schizophrenia and their families have to live with an extraordinary amount of stigma in addition to receiving services ranging from mediocre to nonexistent. Schizophrenia is the modern day equivalent of leprosy, and in the general population the level of ignorance about schizophrenia is appalling.

The result of schizophrenia is often a life sentence for both the person afflicted and for the family. No release, No parole. No time off for good behavior.

Statement of Problem

The problem of this study is to identify dysfunctional family practices and define problems faced by families with a schizophrenic member. Recommendations and guidelines to foster maximum family growth will be offered.

Need for and Purpose of the Study

The situation in which families of mentally ill

individuals found themselves prior to the late 1950s was very different than it is today. At that time, if a loved one developed a clear, severe mental illness, it was relatively easy to find access to care. The sufferer was taken, either voluntarily or involuntarily to a hospital. As often as not, the patient remained in the hospital for many years, if not for a lifetime, as treatments , although vigorous and well meaning, were rarely successful. Relatives and professionals generally had little contact following the initial ones in which relatives were counseled to expect no miracles and to resume their lives at home with the understanding that the patient would be gone for a long time. Visiting the patient was also discouraged for a number of reasons. Among these was the common observation that family visits sometimes seemed to cause patients to become agitated. Gradually, families came to be seen as the carriers of the still undefined societal pathogen (Rothman, 1971).

Things have changed dramatically for families of the mentally ill over the last thirty-five years. Families more and more find themselves playing an integral role in the caretaking network.

It is generally acknowledged that family burden has been underassessed (Bernheim & Lehman, 1985).

However, studies do indicate that relatives suffer emotional, marital, and health problems as a result of living in a permanently anxiety-producing, insoluble situation (Creer & Wing, 1974; Doll, 1976; Grad & Sainsbury, 1968; Hatfield, 1978).

The purpose of this study is to fulfill a need that families with a schizophrenic member have for recommendations that will enable the family to better deal with the issues encountered.

Definition of Terms

The following definitions are synonymous with the context of the paper.

Behavior Therapy: A therapy in which a particular behavior(s) is targeted for treatment which would result in behavior modification or behavior change.

Communication Deviance (CD): As defined by Singer and Wynne (1965), communication deviance refers to a confusing, unclear communication style that leads to a disruption in the focus of attention.

Diagnosis: A diagnosis is the identification of a disease according to its signs and symptoms.

Dysfunctional Practices: These are practices of family dynamics that do not nurture family growth, but ones that cause deterioration of the relationships within a family unit.

Expressed Emotion (EE): A concept which involves the expressed feelings within family relationships, and how these feelings influence the course of schizophrenia.

Family Therapy: Therapy in which the family enters counseling sessions together and the therapist renders treatment to the family as a unit.

Index Case: Baron and coworkers (1985) defined an index case as a patient being studied that has a schizophrenic element in the family: either self, parent, sibling, or other biological relative.

Mental Illness: Mental illness is a disease of the brain that affects how someone feels, thinks, and behaves.

National Alliance for the Mentally Ill (NAMI): NAMI is a national network of families that are affected by serious mental illness and aware of the enormous difficulties that these disorders bring to families. NAMI's goal is to provide information and resources that will make it easier to deal with the mental illness in your family.

Schizophrenia: Johnson (1990) summarized the diagnostic criteria for this illness using the DSM-III-R as (a) presence of psychotic symptoms (such as delusions, hallucinations, incoherence, marked

loosening of associations, catatonic behavior, inappropriate affect); (b) affective disorders and organic causes have been ruled out; and (c) disturbance must last at least six months (including prodomal, active, and residual phases).

Research Questions

The writer will address the following research questions:

1. What are the dysfunctional practices of families with a schizophrenic member?

2. What are obstacles encountered by families with a schizophrenic member?

3. What are guidelines that foster maximum family growth?

4. What kind of programs develop and nurture optimal growth in families with a schizophrenic member?

5. What counselor related variables would be a viable solution to the problems encountered?

Methods and Procedures

The ALICE on-line computer was completed searching the Alden Library of Ohio University. The subject headings used were: Schizophrenia; Family Relationships, Mental Illness and the Family. Several text listings were identified. A search of listings

in the Educational Resources Information Center (ERIC) of the Morrow Library at Marshall University was completed using the headings listed previously. The American Association of Counseling and Development (AACD) was searched with a bibliography of pertinent information forwarded for research. The National Alliance for the Mentally Ill (NAMI) organization forwarded a packet of information to be utilized. Articles, tapes, pamphlets, and books from subject professionals, conferences and centers were also searched and utilized. As many pertinent sources as possible were incorporated into the search for information on the topic, "Schizophrenia and the Family."

Statement of Limitations

This paper was limited to information that dealt with schizophrenia from the perspective of the family, which narrowed the problem to a workable one.

The parameters of this topic were to attain information in articles, books, tapes, and interviews which focused on the family with a schizophrenic member. The information was limited to accessibility and datedness of the information.

Organization of Chapters

Chapter One introduces the topic, "Schizophrenia

and the Family." A statement of the problem under study, and a description of the need an purpose is given. Included in this chapter are definitions of important terms, questions which will be researched and analyzed, and at the end of the chapter are the limitations encountered while doing this research.

Chapter two is a review of the literature. This review will include (a) the literature's listing of dysfunctional practices of families with a schizophrenic member; (b) problems encountered by families with a schizophrenic member; and (c) guidelines and programs that would develop and nurture optimal family growth.

Chapter Three discusses and analyzes the literature reviewed.

Chapter Four summarizes the literature conclusions about families with a schizophrenic member. Recommendations to foster maximum family growth will be included.

CHAPTER TWO

A Review of the Literature

This chapter will review the literature concerning schizophrenia from the perspective of its impact on the schizophrenic's family. The literature will be subtitled under the following:

1. Understanding the causes of schizophrenia
   Overview of mental illness
   Theories of causation
2. Obstacles encountered by families
3. Coping strategies for families
4. Treatment options for families
5. Counselor variables that influence treatment

Understanding the Causes of Schizophrenia

Overview of Mental Illness

Not knowing the cause of schizophrenia has led to various beliefs one of which is that it is the fault of the family (Torrey, 1988). This section endeavors to give a brief overview of mental illness, of which schizophrenia is the most common, and site the multifactorial causations of schizophrenia enabling a clearer understanding of this disease by the family.

The specific types of mental illness differ, but they all interfere with how someone feels, thinks, and

acts. They disturb not only the lives of the persons with the disease, but the lives of those who care about them (Johnson, 1989).

Because schizophrenia affects how people think and interpret what is going on around them, they often act strangely. Those who live with or are close to a schizophrenic are affected by their peculiar, sometimes frightening, behavior. Sharing a home with someone who has schizophrenia is difficult, and much more common than you think. At least one in four families has a member with a serious mental illness like schizophrenia or depression (Johnson, 1989).

Theories of Causation

There are many theories as to the cause(s) of schizophrenia. Studies of schizophrenia have been complicated by the ever-changing case definition. Since 1987, the Diagnostic and Statistical Manual of Mental Disorders, ed 3, revised (DSM-III-R) has provided current diagnostic criteria for a more standardized case definition.

A summary of DSM-III-R diagnostic criteria for schizophrenia are (Johnson, 1990) (a) presence of psychotic symptoms (such as delusions, hallucinations, incoherence, marked loosening of associations, catatonic behavior, inappropriate affect);

(b) affective disorders and organic causes have been ruled out; and (c) disturbance must last at least six months (including prodomal, active, and residual phases). Still, many researchers believe that what we recognize as schizophrenia today is really a number of different diseases with a similar clinical presentation (Johnson, 1990). These varied definitions over time complicate fair comparison of studies and pooling of data. The various research suggest that three factors together may contribute to schizophrenia (Johrson, 1989). These factors are:

1. The genetic makeup of an individual.

2. Environmental and family experiences of an individual.

3. The biochemical imbalance in an individual.

Genetic Research

Genetics provides one basis for a biologic explanation of schizophrenia. Schizophrenia has been studied using twins, adoption, family history, family studies, and studies of biologic markers to identify genetic components, if any (Johnson, 1990).

Twin studies. Studies of twins, monozygotic and dizygotic, permit the study of both genetic and environmental influences on disease. If schizophrenia is genetically controlled, monozygotic twins (with the

same genotype) should have a higher concordance rate for schizophrenia than same sex dizygotic twins (with differing gentotypes). Dizygotic twins of the same sex are studied to control for environmental differences between male and female in a twin pair.

Though this hypothesis seems simple, testing it is complicated by the low rates of schizophrenia and twin births, errors in assessing zygosity, and changing and imprecise definitions of schizophrenia.

The first systematic twin studies were completed in the early 1900s. Gottesman and Shields summarized the early twin studies by Luxenburger (1928), Rosanoff (1934), Essen-Moller (1941), Kallman (1946), Slater (1953), and Inouye (1961). The range of concordance among the monozygotic twins ranged from 58% to 69%; the range in the same-sex dizygotic twins was from 0% to 15%. In each study, the concordance rate for monozygotic twins was about four times (or more) the rate in same-sex dizygotic twins. This trend emerged in spite of variations in study populations, completeness of case finding, small sample sizes, variable use of age corrections, and lack of standardized diagnoses (Gottesman, Shields, 1982).

More recently, additional twin studies have been reported (in American veteran and British, Finnish,

Norwegian, and Danish twins). In each study, the monozygotic probandwise concordance for monozygotic twins varied between 35% and 58%; for same-sex dizygotic twins between 9% and 27%; the weighted averages were 46% and 14%, respectively. Most studies found the difference in concordance to be greatest for "definite schizophrenia" and less for the "spectrum of schizophrenic illness" (Kendler, 1983).

These twin studies, though different in sample size, schizophrenic diagnostic criteria, case ascertainment, and general methodology, show similar results: higher rates of schizophrenia concordance in monozygotic twins as compared with same-sex dizygotic twins.

Adoption studies. Biologic and adoptive families of schizophrenics have also been studied. Heston published the first adoption study of schizophrenics in 1966. He compared adopted-away infants born to hospitalized schizophrenic mothers (experimental group) to adopted-away infants born to normal mothers (control group). He found a 16.6% age-corrected rate of schizophrenia among the adoptees in the experimental group and no schizophrenia in the control group.

Another study of adoption was done with the

advantage of complete adoption and psychiatric hospital records. By cross-linking adoption and psychiatric hospitalization records, various study populations could be identified, such as adoptees who became schizophrenic, adopted-away children of schizophrenic parents, or adoptive parents who later became schizophrenic. These data have been analyzed from many perspectives: the rates of schizophrenia in adopted children with one or both biologic parents being schizophrenics were compared with control adoptees whose biologic parents were free from psychiatric illness (Rosenthal, Kety et al, 1971); rates of schizophrenia in adoptive and biologic families of schizophrenic adoptees were compared (Kety, 1971); and the rates of schizophrenia in adoptees whose adoptive parents became schizophrenic were compared with controls (Wender, 1974).

Rosenthal and colleagues (1971) compared 32 adoptees (index cases) with at least one schizophrenia-spectrum biologic parent to 67 control adoptees with no parent known to be schizophrenic. He reported 31.6% of index cases later developed a schizophrenia-spectrum disorder compared with 17.8% of controls. He also concluded that though the differences between cases and controls were

statistically significant, this high rate of disease in controls deserves further exploration.

Kety and associates (1971) compared the rates of schizophrenia spectrum illness between biologic and adoptive family members of 33 schizophrenic adoptees and a similar number of controls. Of the schizophrenia-spectrum adoptees, they found 13 (8.7%) of 150 biologic relatives with some schizophrenic disorder as compared with 3 (1.9%) of 156 controls. Statistical significance remained when a subsample of children separated from their biologic parents within one month of birth was analyzed. Further, the adoptive relatives of cases and controls had similar rates of schizophrenic disorder, 2 (2.7%) of 74 and 3 (3.6%) of 83, respectively.

Kety and associates (1975) updated their earlier work with interviews and continued to find an increase in schizophrenic disease in the biologic relatives of schizophrenic (index case) adoptees, but not in the adoptive relatives. The data and statistical analysis in these studies have been controversial (Lidz, Blatt, Cook, 1981). An independent analysis of the data was prepared by Kendler and Gruenberg (1984) using the DSM-III diagnostic criteria for case ascertainment. They concluded, "The results of this study are

compatible with the hypothesis that schizophrenia occurs through an interaction of genetic susceptibility and environmental stress".

A third approach was to study children who were adopted into homes where one of the adoptive parents later became schizophrenic. Three variables were examined:

1. Cross-fostered adoptees with "normal" biologic parents and at least one schizophrenic adoptive parent.

2. Index adoptees with at least one biologic parent carrying a schizophrenia-spectrum diagnosis and "normal" adoptive parents.

3. Control adoptees with "normal" biologic and "normal" adoptive parents.

Of the three groups, the index adoptees had the highest rate of schizophrenia. However, the control and cross-fostered groups had higher than expected rates of schizophrenic-spectrum disorders, so the authors questioned whether the control group was actually a non-biased representative sample. On further examination, one third of a sampling of control biologic parents was found to have had a schizophrenic-spectrum disorder, though the subjects were not hospitalized (Wender, Rosenthal, Kety, et al,

1974).

The researchers were unable to draw definite conclusions from this study. However, they did note the adoptive schizophrenic parent had no identifiable schizophrenogenic influence on the adoptive child, which would be inconsistent with a fully environmental cause.

Family history and family studies. Family history and family studies review the family psychiatric history of a schizophrenic patient (index case) to construct at least a limited pedigree. Both of these types of studies have an advantage over twin and adoption studies in that larger sample sizes were much easier to obtain. Their primary disadvantage is the lack of control over environmental factors.

Baron and coworkers (1985) studied 90 schizophrenic patients and their 376 relatives (180 parents, 196 siblings) and a similar number of controls and their relatives (180 parents, 194 siblings). The family members were individually contacted when possible; otherwise family history was obtained. Schizophrenia was reported in 8.7% of siblings of patients and 3.3% of their parents. The comparable rates for controls were 1.2% and 0%, respectively. Baron and coworkers conclude that this

supports the familial nature of schizophrenia.

Kendler and associates (1985) pooled data from the "Iowa 500" and "non-500" subjects to identify 332 patients meeting DSM-III criteria for schizophrenia, of which 253 patients had one or more relatives who could be followed up with a personal interview or a psychiatric hospital record. The schizophrenia morbid risk was at least 18 times greater in the first-degree relatives of schizophrenics than in the first-degree relatives of controls (surgical patients).

Unlike Kendler and associates, Pope and coworkers (1982) and Abrams and Taylor (1983) found similar schizophrenia rates in family members of patients and controls. These studies have been understandably controversial; various authors have criticized them on methodologic grounds (Kendler, 1983; Weissman, 1983; Kety, 1983).

Biologic markers. Biological science is close to proving that schizophrenia is a neuropathological disease process. Although the etiology is unknown, it does not appear to correlate with family systems, early attachments, communication styles, or environmental stress (Taylor, 1987). In the past, direct observation of neurological changes in the brains of schizophrenics was impossible. As a result,

many studies that found hints of physiological differences were inconclusive and could not be replicated (Taylor, 1987). Neuroscience has not acquired tools that allow for more direct methods of research on the brain. The new results, which often can be replicated, have dramatically linked schizophrenia to organic brain pathology (Taylor, 1987). A brief description of these techniques follows:

1. Computerized axial tomography (CAT scan). Weinberger and Kleinman (1986) reviewed over 30 significant CAT scan studies of schizophrenia, summarizing the work that had been accomplished from the first project in 1976 to the present. They concluded that the vast majority of these studies found evidence of structural brain pathology in schizophrenia.

2. Magnetic resonance imaging (MRI). The CAT scan is being replaced by magnetic resonance imaging (MRI). The MRI has higher resolution images, is able to focus on more defined or restricted area of the brain, and is less interfered with by bone structures. Furthermore, MRI does not expose the individual to radiation and may be repeated or updated more often.

3. Positron emission tomography (PET scan). Only

a few PET scan studies have been performed with schizophrenic patients, and they have been inconsistent and exploratory in nature. Their results have suggested that schizophrenics, compared to control groups, have reduced frontal lobe functioning both in schizophrenic patients who are receiving psychotropic medications and in those who are not (Buchsbaum, 1984).

4. Regional cerebral blood flow (rCBF). In 1986, the National Institute of Mental Health (NIMH) completed two studies that used this technique. The researchers discovered that patients with schizophrenia demonstrated significantly reduced frontal lobe activity during problem-solving periods, but that control individuals showed increased frontal lobe activity upon stimulation. However, the flow of blood in the normal control individuals and in the schizophrenic patients seemed to be about the same.

5. Brain electrical activity mapping (BEAM). The rCBF studies have been corroborated by BEAM. Morihisa, Duffy, and Wyatt (1983) substantiated the hypotheses (a decrease in the flow of blood to the frontal lobe should create an increase in what is referred to as delta activity), were able to replicate these frontal lobe findings, and document differences

in the posterior brain activity of schizophrenics and of control groups.

Two types of biologic markers have been sought: a biologic correlate (such as HLA type), and an actual genetic locus responsible for schizophrenia. A genetically transmitted biologic correlate would be a characteristic common among schizophrenics but uncommon in the general population. Thus, it would seem to be genetically transmitted with schizophrenia. Several recent reviews have described the range of biologic markers studied, but none of these markers has been shown to be specifically correlated with schizophrenia (Mirsky, Duncan, 1986; Murray, Reveley, McGuffin, 1986; McGuffin, Stuart, 1986; Baron, 1986).

The correlation of specific genetic markers including HLA types, ABO-blood groups, and Gc with schizophrenia has been studied. McGuffin and Stuart (1986) note that HLA-A9 and paranoid schizophrenia is the best correlated of these markers. Though no biologic marker has been found that is either sensitive or specific for schizophrenia, the search continues.

Environmental Research

The person who will be schizophrenic begins life and usually grows up in a family, so many theories

have evolved about how family experience sustains, augments or causes schizophrenia (Scheflen, 1961). The marked increase in interest in the study of families has resulted in careful examination of how children are affected by parental psychopathology and disordered communication patterns within families. The claim has been that schizophrenic children are the product of seriously and characteristically disturbed families (Howells, Guirguis, 1965).

An exploratory study of interrelations between the performance of social roles in families and schizophrenia was completed in 1965 by Rogler and Hollingshead. Puerto Rico had been chosen as the field site because coping with mental illness is almost exclusively the responsibility of the family.

The study group was composed of twenty families, each containing a schizophrenic husband, wife, or both; the control group was composed of spouses who were mentally healthy. Detailed data was gathered on three generations in each family.

The three basic questions underlying the research were:

1. Is the life history of a person who develops schizophrenia markedly different from one who does not?

2. When and under what conditions do symptoms become evident to the afflicted person, his family, and his associates?

3. What are the effects of schizophrenia on the families?

Briefly stated, the findings indicate that experiences in childhood and adolescence of schizophrenic persons do not differ noticeably from those of persons who are not afflicted with this illness. At an identifiable period in the life of the schizophrenic person, however, relationship problems produce symptoms which overwhelm the victim and prevent the fulfillment of his/her accustomed social roles. The impact of schizophrenia on the family depends on the sex of the person afflicted (Fengler; Hollingshead, 1965).

Other studies have involved the effects of parental psychopathology and maltreatment on child behavior with identification of the risk factors. In the case of research on the offspring of schizophrenic parents, it is assumed that inherited genetic liability interacts with environmental stress in the production of psychopathology (Walker, Cudeck & Mednick, 1981; Walker & Emory, 1983). Investigators have hoped to be able to identify markers of genetic

vulnerability that predate the onset of psychiatric disorder. The identification of such markers would serve two functions: (a) to provide a basis for identifying children for primary prevention, and (b) to elucidate the nature of the developmental trajectory that leads to schizophrenia.

This study examined the main and interactive effects of parental psychopathology (schizophrenia, psychiatric control, and normal control) and maltreatment on child behavior. The subjects of the study were drawn from a total sample of 144 children participating in a longitudinal investigation of risk factors in development. Child aggression, delinquency, and social withdrawal were assessed at two different times so that the effects of risk factors on behavioral change could also be examined. The results indicate significant relations between the risk factors and child behavior. Most notably, parental psychiatric status and maltreatment interacted significantly, such that offspring of schizophrenic parents from maltreating families showed increases in externalized behavior problems over time (Walker, Downey, Bergman, 1989).

There has been a lot of interest regarding the concept of expressed emotion (EE); in particular the

posited influence of family relationships on the course of psychiatric illness. The broad purpose of the following studies was to search for some environmental explanations of relapse in schizophrenia.

The first investigation was a study of 229 discharged chronic male patients who had been inpatients for two years or more (Brown, Carstairs, Topping, 1958). Two findings seemed worthy of further study. First, there was a significant link between symptomatic relapse and the type of living group to which a patient returned. Patients returning to live with parents or a wife were significantly more likely to relapse than were other patients. Second, for patients returning to live with a mother, clinical outcome was highly related to whether one, or both, worked outside the home. Some patients seemed to be reacting against close ties with relatives outside the home.

A second study (Brown, Monck, Carstairs, Wing, 1962) was designed to test some of the competing explanations for the first set of results. More direct measures of family relationships were developed. In the year after discharge, three-quarters of the patients returning to "high emotional

involvement" homes relapsed with florid symptoms, compared to less than one third of the remaining patients.

The main results of the study by Brown et al. (1972) were replicated successfully in follow-up studies carried out in London (Vaughn, Leff, 1976) and in Los Angeles (Vaughn, Snyder, Jones, Freeman, Falloon, 1984). The relapse figures in these studies were very similar. In each instance, patients returning to high EE homes after hospital discharge were three to four times more likely to relapse during a nine month follow-up period than were patients returning to low EE homes.

In recent years, additional evidence suggests that the EE index has predictive validity where relapse patterns in schizophrenia are concerned. Results of a longitudinal study of recent onset patients also found that high EE predicted relapse, even when medication was standardized and ensured through depot administration (Nuechterlein, Snyder, Dawson, Rappe, Gitlin, 1986). These replications of the original group of studies are distinguished by their comparable approaches to diagnosis, EE assessment, and the definition of relapse as the return of schizophrenic symptoms.

Other studies however have found discrepant results when other variables were considered along with the EE index. Moline, Singh, Morris and Meltzer (1986) found a positive relationship between relatives' EE and relapse only when the usual EE threshold for criticism was raised from six to nine critical comments. MacMillan, Gold, Crow, Johnson and Johnstone (1986) suggested that the relationship between EE and relapse in a sample of recent-onset patients was mediated by another variable, the duration of untreated illness between first onset of symptoms and initial hospitalization. A similar confounding of high EE status and duration of untreated illness was found by Parker and Johnson (1987), who notably failed to find any independent EE effect on outcome. Differences in design, methodology, and interpretation of the studies may explain the discrepant results in the research.

The strongest evidence of a causal role for EE comes from family treatment studies. The EE research has stimulated psychoeducational approaches to helping families of the mentally ill, as well as more intensive family intervention programs for the management of schizophrenia. Elements of these controlled trials have included educating the family

about the illness, improving communication within the family, teaching problem-solving skills, helping patient and relatives to express negative feeling in more constructive ways, and developing more realistic expectations for social functioning and performance. These approaches have noted considerable success in meeting their goals. (Goldstein et al, 1978; Falloon et al, 1982; Leff et al, 1982; Boyd et al, 1985; Kuipers et al, 1985; Hogarty et al, 1986; Tarrier et al, 1988).

Recently the EE research has been criticized as the latest exercise in blaming the family of the schizophrenic patient, since it appears to place families into categories labelled "bad" (high EE) and "good" (low EE) (Hatfield, 1987; Kanter, 1987).

Research has also studied the role of parental communication deviance (CD) in childhood onset schizophrenia. Research on children at risk for schizophrenia suggests that schizotypal symptoms such as social isolation, inadequate social rapport and signs of thought disorder may be childhood precursors of adult onset schizophrenia (Asarnow, Goldstein, 1986).

One of the most replicated findings in the literature on families of adult schizophrenics is that

these families tend to show low levels of communication clarity and accuracy (Goldstein, Doane, 1982). Much of this research utilized the construct of communication deviance. As defined by Singer and Wynne (1965), the communication deviance (CD) refers to a confusing, unclear communication style that leads to a disruption in the focus of attention.

Joan R. Asarnow, Michael J. Goldstein , and Sharon Ben-Meir (1988) conducted a study in which the rates of parental communication deviance (CD) were compared in children with schizophrenia and schizotypal personality disorder and in contrast groups of children with major depression and dysthymic disorders. Major findings of this study were: (a) CD was significantly more frequent in parents of schizophrenic and schizotypal children than in parents of children with depressive disorders; (b) comparable levels of CD were found in parents of schizophrenic and schizotypal children and in parents of children with major depressive and dysthymic disorders; (c) CD factors, faulty misperceptions, and failure to integrate closure problems, were the most significant factors for differentiating children with schizophrenic spectrum disorders and children with depressive spectrum disorders; (d) the subset of

schizophrenic and schizotypal children from high CD families showed the most severe impairment and the poorest attention functioning in the sample. The present results indicate strong associations between childhood onset schizophrenia spectrum disorders and parental communication deviance. These data also indicate that CD is not specific to schizophrenia spectrum disorders.

Four limitations of this study are:

1. Although a transactional model of the impact of CD is implied, the measure used in this study was administered individually to parents. Future research employing direct parent-child interaction measures is required to explicate processes by which CD may impact upon child behavior and child behavior may impact on parental communication patterns.

2. This study does not provide a means of ascertaining whether parental CD preceded the onset of child symptoms.

3. Relationships between the demands that the WISC-R subtests make on attention processes and other laboratory measures of attention have not been determined.

4. The WISC-R was administered during hospitalization at a time when scores are likely to be

depressed due to the child's level of disturbance.

Other theories as to familial causations of schizophrenia are: Theories of Excessive Interdependency, Theories of Homeostasis and Stalemate, and the Double Bind Theory (Scheflen, 1981). These theories all deal with family interactions and will be briefly described.

The theory of excessive interdependency describes an excessive symbiosis between mother and child in instances which would result in schizophrenia. It is also claimed that family members in schizophrenia lack self-differentiation or autonomous ego strength (Mahler, 1965).

The theory of homeostasis and stalemate holds that the members of the schizophrenic family primarily the parents -are entrenched in a stalemate or homeostasis relationship, so that no change or maturation is possible. The schizophrenic member is believed to somehow manifest or live out the stalemate (Palazzolo, 1978).

The double bind theory was hypothesized by Bateson, Jackson, Haley and Weakland in 1956. In this theory the child who will be schizophrenic is subjected throughout childhood to a contradictory set of instructions. To obey one kind is to disobey the

other. The child can not escape this conflicting field of developmental forces. The limitation to this theory it that the hypothesis of double-bind has not been statistically tested.

The question is still open whether the family's behavior, habits, and communication patterns cause schizophrenia. Now, many authorities suspect that the families of schizophrenics seem disturbed mainly because they have to live with a severely disturbed person (Harvard Medical School, 1980); however, research needs to be conducted in this area.

Biochemical Research

The biochemical theory most widely accepted today assumes that the symptoms of schizophrenia result from having too much of the brain chemical dopamine and not enough of several other neurotransmitters (Taylor, 1987). Researchers continue to study the neurotransmitter dopamine because an increase in dopamine is associated with increased symptoms of schizophrenia. However, when dopamine receptors are blocked with neuroleptic drugs, the schizophrenic symptoms often decrease. Kaufman (1984) found that chronic schizophrenics who have responded poorly to treatment have decreased levels of dopamine sulfate.

This concludes the section of the causations of

schizophrenia. The next section discusses obstacles encountered by families with a schizophrenic member.

Obstacles Encountered by Families

Families with a schizophrenic member face an array of problems requiring solutions. Deinstitutionalization, which was intended to do a better job of integrating psychiatric patients into the mainstream of society and to make their lives more normal, has not accomplished its goals. Families have become a "dumping" ground, unprepared for the trauma of managing a schizophrenic relative (Iodice, Wodarski, 1987). Books and advice from other families may be helpful in offering suggestions, but in the end each patient with schizophrenia and each family are unique.

Research on the strains of living with psychiatrically impaired persons is relatively sparse despite its pronounced social importance in an age of deinstitutionalization (Noh, Turner, 1987). Literature has developed on family burden, typically encompassing two descriptive categories. "Objective burden" deals with the actual, objective problems and "subjective burden" with the psychological distress engendered by the illness (Lefley, 1989). The common objective burdens listed were: families experience

financial hardships due to medical bills and the patients' economic dependency, disruptions of household functioning, curtailment of social activities, and altered relationships with friends and relatives because of the excessive demands of caregiving. Typical also is the attention focus on the patient together with time commitments that often lead to neglect of others in the family (Black, Cohn, Smull, Crites, 1985; Lefley, 1987). In many cases, the illness necessitates role and occupational changes for the major caregiver.

Subjective components encompass the stressors families experience in the form of periodic crises, involuntary commitment procedures, and difficulties in finding appropriate alternatives to hospitalization (Lefley, 1989). Surveys of family experiences show the effects of stress on the psychological and sometimes the physical health of caregivers, the inability of caregivers to make or fulfill personal plans, and their worries about what will happen to the patient "when I am gone," particularly among elderly parents of chronic patients (Lefley, 1987).

Research indicates the following problems are routinely encountered by families with a schizophrenic member:

1. Should the person live at home? A very important decision to be made by someone with schizophrenia and their family is where the person should live. Currently it is estimated that approximately two thirds of discharged mental patients return to live with their families (Goldman, 1982). If the patient stays with the family then various tasks must be resolved. Among these tasks are: (a) creating an environment that balances the needs of ill and well members alike; (b) finding quality health service; (c) learning to cope with the family member's illness; (d) learning to recognize relapse symptoms; (e) coping with intrafamilial conflict that occurs in conditions of chronic stress and strain; (f) handling the issue of stigma; (g) finding some way to resolve the guilt, anger, frustration, fear, and grief that can be debilitating (Bernheim, 1989).

2. How should family members behave toward someone with schizophrenia? There are certain aspects of schizophrenia as a disease which causes persons with schizophrenia to have great difficulty in processing sensory input of all kinds, especially two or more simultaneous stimuli. Suggestions are to make communications brief, concise, and unambiguous. (Torrey, 1988).

3. How much responsibility? One of the most challenging problems for families with a schizophrenic member is to assess how much responsibility the person is able to take and how much control he or she has over his or her own behavior. It has been suggested that the issue of responsibility be resolved by open discussion of what is expected, what is fair, and what the person has to do to achieve more independence. It also suggested to include the patient's psychiatrist, counselor, social worker, or case manager in such discussions (Taylor, 1987).

4. Violence and aggression. Knowing what to do in the event of the schizophrenic family member becoming violent and aggressive presents difficult problems for the family (Torrey, 1988).

5. Caffeine, nicotine, alcohol, and street drugs. The use of these substances by schizophrenic family members is often of concern by families stemming from the effects these substances have on schizophrenia. It has been suggested that the family address these concerns with the patient's doctor (Torrey, 1988).

6. Sexual issues. Some persons with schizophrenia have little interest in sexual relationships. Many others, however, do have an interest. Among the biggest problems for the families

are contraception, genetic counseling, and their embarrassment about that interest (Torrey, 1988).

2. Sibling problems. The family may be faced with problems from the other siblings of the family. These problems may be in the form of embarrassment, anxiety, jealousy, and anger (Torrey, 1988).

3. Guardianship and plans for the future. One of the most troubling problems for families with a schizophrenic family member is what will happen after the family members who are providing the care die. Guardianship is a legal relationship authorizing one person to make decisions for another and is based upon the same "parens patriae tenet" of English law which permits involuntary hospitalizations (Tarley, 1987).

Another mechanism used by some families to plan for the future are nonprofit organizations founded by groups of families. These organizations will accept responsibility for the schizophrenic family member after the death of the well family members (Tarley, 1987).

It is generally acknowledged that family burden has been underassessed (Bernheim, Lehman, 1985). Studies indicate that relatives suffer emotional, marital, and health problems as a result of living in a permanently stability producing, inescapable situation

(Creer, Wing, 1974; Doll, 1976; Grad, Sainsbury, 1968; Hatfield, 1978). Furthermore, innovative community based programs that improve patient outcome often do not appear to relieve family burden substantially (Endicott, Herz, Gibbon, 1976; Stein, Test, 1980).

These summarize the common problems confronted by families with schizophrenic members. The next section of the paper deals with coping strategies that the families may find useful when addressing these problems.

Coping Strategies for Families

If families are to survive schizophrenia they have to develop coping strategies to the many problems which arise. Research stipulates that developing the right attitude is the single most important thing a family can do to survive schizophrenia (Lorrey, 1978).

Two components that are obstacles to the right attitude are blame and shame. Once blame and shame have been put aside the right attitude can evolve. The right attitude has four elements and can be called a CARE attitude: Sense of humor, Acceptance of the illness, Family balance, and Expectations which are realistic.

Other coping strategies cited by Lorrey are (a) answers to common problems, (b) supportive

siblings, and (c) family support groups.

The next section of chapter two concerns treatment options for families with a schizophrenic member.

Treatment Options for Families

In the past 15 years, the way mental health professionals view families of the chronically mentally ill changed dramatically, largely because of the emergence of the biological theories of causation for schizophrenic disorders (Walsh, 1988). Concurrently with this theoretical shift was the concept of deinstitutionalization which has made families the primary caretakers for most chronic schizophrenics living in the community. This has caused a great dilemma for families due to the unpreparedness for the task. Those investigating the needs of these families have found that knowledge, skills, and group support are essential for the families' effective coping. Specific recommendations for mental health intervention include the following (Falloon, Boyd, McGill, 1984):

1. Educating the family and social network about the nature and management of schizophrenia.

2. Teaching more effective nonverbal and verbal communication.

3. Teaching more effective problem-solving skills.

Joseph Walsh (1988) proposes five areas for a family educational intervention plan: diagnosis, medications, community resources, therapy techniques, and engaging the unmotivated client relative. This plan utilizes social workers as family educators about schizophrenia. The goals of this comprehensive treatment plan are: (a) help families enhance their objectivity, (b) develop reasonable expectations for client change, and (c) take better care of their own needs. Such assistance may increase the potential for client rehabilitation (Carpenter, 1990).

In Tucson, Arizona, services to families have developed to form a comprehensive intervention package called the Family Support Project (FSP). The FSP consists of five phases of multifamily groups. Families may systematically proceed through each phase or may stop when needs have been met. These phases are:

1. Crisis group. The purpose of this phase is to fulfill a need that families have to ventilate, identify with other families, and sort out their feelings.

2. Education class. At this phase families

learn how the world is perceived through the eyes of the mentally ill person when in a psychotic episode, and how to manage this behavior.

3. Skills training. The PSP skills training program includes direct instruction, modeling, role play and the specific skills taught include communication, assertiveness, behavior management, and problem solving.

4. Support group. The fourth phase of the PSP consists of a long-term support group in which the families are able to meet once monthly to provide each other with both support and information.

5. Task group. The fifth phase of the PSP has evolved from the families' desire to work together and has been termed by them, the Family Education and Support Project (FESP). In this group, education, skills, and support come together as a catalyst to strengthen families and to provide the group cohesiveness necessary for families to continue forward as a unit. This intervention plan is still in the preliminary stages of evaluation as an effective intervention, but it is hoped that this plan will enhance the lifestyles of their ill family members (Ferris, Marshall, 1987).

Goldstein et al's (1978) specific model of family

intervention requires that (a) patient and family come to accept the patient's psychosis; (b) they attempt together to identify probable precipitating stresses in the life of the patient that bring on psychosis; (c) they attempt to generalize about future stresses to which the patient and family may be vulnerable; and (d) they plan together to minimize or avoid these future stresses.

In the estimation of Goldstein et al., such an organized aftercare program diminishes the "revolving door syndrome" that brings on a crisis in the lives of schizophrenic individuals and their families. This approach provides support and relief by professionals to help families adjust to having their schizophrenic relative at home.

Proponents of the psychoeducational approach to family treatment acknowledge that families probably interact with their schizophrenic family member at a high level of EE. They state that in their model a variety of supportive and educational techniques are used to lower the emotional temperature of the family while maintaining sufficient pressure on patients to avoid the pitfalls of negative symptoms (Anderson, Hogarty, Reiss, 1980). Anderson and her colleagues have developed a long-term highly structured,

supportive psychoeducational series for families with a schizophrenic member. Their empirical data are not complete at this time. However, their preliminary impressions have been favorable. They noted that of the 12 parental families involved over a 15-month period, no dropouts or relapses occurred , and it appeared that certain families were indeed receptive to long-term management of schizophrenia via professional support and concrete information.

There are four phases to this program: phase I: Connection; phase II: Survival skills workshop; phase III: Reentry and application; phase IV: Maintenance. It was noted that early in the process, families developed increased coping skills through exposure to other parents struggling with similar issues and problems (Anderson, Hogarty, Reiss, 1980). It also appeared that the creation of a support network through in-depth contact and interaction with other families in similar situations provided an ongoing source of support, desensitization, and normalization about the issue of schizophrenia in the family. Falloon, Boyd, and McGill (1980) conducted psychoeducational groups in the homes of parents of schizophrenics to minimize missed appointments and low attendance and to help patients generalize learning to

family situations. Falloon et al., McClean et al., and Zelitch conducted their psychoeducational family intervention in treatment facilities (Falloon, et al., McClean et al, Zelitch, 1982). Success appeared to be equal whether sessions were conducted at home or in a facility.

McGill did a follow-up study of patients whom received the family psychoeducational model of intervention and those whom received only individual treatment. In the psychoeducational model, parents and patients showed a significant gain in knowledge between the baseline and follow-up period, whereas those in individual treatment demonstrated no significant changes (McGill, 1980).

In 1989 Ira Abramowitz, and Robert Coursey did a study on the impact of an educational support group on family participants who take care of their schizophrenic relatives. It was hypothesized that, in comparison with a control group, the participants in the education/support group would experience a decrease in the amount of distress and anxiety and a decrease in their negative feelings toward their mentally ill relatives, as well as an increase in their sense of self efficacy, an increase in their use of community support services, and better management

of their home lives.

Using a stress-coping framework, the program was a six-session educational support group offering family caretakers information about schizophrenia, training in problem-solving skills for managing patient behavior, and greater access to social support and community resources. Results of the program indicated a significant difference between the experimental and control caretakers following the intervention. Caretakers of the educational support group reported reduced anxiety and personal distress and more active coping behaviors. However, no changes were reported in the frequency of their negative feelings toward their mentally ill family member or in their generalized sense of self-efficacy (Abramowitz, Coursey, 1989).

Dellario and Anthony (1981) reviewed research that compared day hospitalization, in-home care and community clinics, and hospitalization. They concluded that although community treatments are superior while they are ongoing, once treatment is withdrawn there is no significant difference in symptom reduction, psychosocial functioning, interpersonal functioning, or personal adjustment. Gains seen in the community groups' vocational rates

and employment status fell off after approximately 18 months.

Kiesler (1982) reviewed the experimental literature on alternatives to hospitalization for relevance to policy decisions. He argued that it is likely that too many people are being institutionalized and that the amount of hospital care provided could be significantly reduced if adequate initial community care were available. He also concluded that although there are a variety of potentially effective alternative treatments, they do not collectively offer insight for national policy because each program tested its own method of care.

Mutual-help organizations provide a source of community support. One such organization is GROW. GROW has three program components: group meetings held weekly, literature, and what GROW refers to as "the sharing and caring community." As in most mutual-help groups, the meetings focus on group problem solving and support, and the literature provides cognitive guidance. The unique aspect of GROW is that it extends beyond weekly meetings to form a community for living. Although an intensive summative evaluation is not complete, the data gathered suggest that GROW both maintains and implements a positive philosophy of

community care (Sales, Seidman, Rappaport, 1988).

The National Alliance for the Mentally Ill (NAMI), is an organization that is dedicated to the eradication of mental illness and improvement in the quality of life of those whose lives are affected by these diseases (NAMI, 1990). NAMI has two kinds of members: families who belong to affiliated self-help and support groups, and "associate members," those who share our concern but do not belong to support groups. NAMI meets a need families and society have for support groups. The following are aspects that NAMI address (NAMI, 1990):

1. Mutual support. Through regular meetings of self-help groups, members help each other cope, get through the hard times, and share information on their experiences with local services and professionals.

2. Public education. Through radio, television, and the press, NAMI is working to educate the public about serious mental illnesses. NAMI chips away at the stigma that still surrounds those who are mentally ill by sharing the facts about the illness.

3. Advocacy. NAMI members advocate for mentally ill people by bringing their problems to the attention of local, state, and federal governments. NAMI seeks improvements in the systems that are meant to serve

the needs of those who are mentally ill.

4. Research. NAMI works with Congress to ensure that the dollars allocated to mental illness research increase each year.

There are several special outreach sections of NAMI.

NAMI Children and Adolescent Network (NAMI CAN). This network is dedicated to improving services and the quality of life for children, adolescents, and younger families who are just beginning to confront the impact of mental illness in their lives.

Siblings and Adult Children's Network. This network provides support, assistance and educational resources to brothers, sisters and adult children of people with serious mental illness.

Ethnic Minority Concerns Network. This network strives to reach minority families and address the needs of minorities in the area of mental illness.

Religious Outreach Network. This network seeks to educate and influence the many religious denominations to increase their understanding of and outreach to people with serious mental illnesses.

Forensic Network. This network offers support to families of persons with psychiatric disabilities in the criminal justice system and seeks to prevent

victims of mental illnesses from being dumped into criminal justice systems.

Curriculum and Training Network. This network is an information exchange/work group for persons who share a common interest in the education of mental illness professionals.

Homeless and Missing Mentally Ill Network. This network offers support, education and assistance to families with missing or homeless loved ones, seeks to reunite families when possible, and works to expand services to assist mentally ill people.

Guardianships and Trusts Network. This network strives to improve the quality of life of those suffering from mental illness through interior effective estate planning, surrogate family services by means of guardianships, wills and trusts.

Client Council. This council advises NAMI of the client perspective of mental illness issues and promotes the involvement of clients in NAMI activities.

This concludes the section on treatment options available for the family with a schizophrenic member. The next section addresses counselor variables that may influence treatment.

Counselor Variables That Influence Treatment

This section looks at the counselor and the perceived impact he/she has made upon the treatment process. Surveys of families indicate general dissatisfaction with the service delivery system in the treatment of persons with major mental illnesses (Hatfield, 1992; Holden & Lewine, 1982; Unger & Anthony, 1984). Families report frustrations in attempting to elicit answers to questions and in dealing with reluctant, ambiguous communications from mental health professionals (McElroy, 1987).

The following are some problems families feel are not being addressed adequately (Backer, Richardson, 1990):

1. There is considerable ignorance among personnel in individual practice and in mental health agencies about the issues of concern to families and about the challenges of practical living families face when a family member becomes mentally ill.

2. There is a lack of needed counseling and therapeutic services for family members themselves.

3. Outdated theories have persisted about the family's role as a causative factor in the development of major mental illnesses such as schizophrenia. Conveying such beliefs to families tends to deepen

CHAPTER THREE

Discussion, Analysis, and Interpretation

Chapter one provided a brief overview of the problem, the need for, and the purpose of the study of schizophrenia from the perspective of the family. Chapter two gave in-depth information gleaned from various sources about schizophrenia and its impact on the family unit. Chapter three is an analysis and interpretation of the data collected in chapter two. Chapter three will integrate the data findings enabling a summation that readers will more readily understand. The chapter will utilize the same subtitles and sequence as chapter two.

Understanding the Causes of Schizophrenia

Finding the reason behind an illness is a logical inquiry by both families and researchers. Schizophrenia, one of the most common mental illnesses, has not afforded researchers or families with an absolute identifiable causative factor. This has led to various theories of causation and left the family feeling responsible for the illness and stigmatized by society.

Genetic Research

Schizophrenia has led researchers into various avenues searching for the cause of this illness. One

of which is genetics research. Schizophrenia has been studied using twins, adoption, family history, family studies, and studies of biologic markers. An analysis of each follows:

Twin Studies. The hypothesis of this research was that if schizophrenia is genetically controlled monozygotic twins (same genotype) should have a higher concordance rate for schizophrenia than same sex dizygotic twins (with differing genotypes). The results of the various studies conclude:

1. A summarization of the early twin studies by Luxenburger (1928), Rosanoff (1934), Essen-Moller (1941), Kallman (1946), Slater (1953), and Inouye (1961) showed a concordance rate, in each study, about four times the rate in same-sex dizygotic twins. What gives credence to these studies is that this trend emerged in spite of variation in study populations, completeness of case finding, small sample sizes, variable use of age corrections and lack of standardized diagnoses (Gottesman, Shields, 1982)

2. The twin studies of American veteran, British, Finnish, Norwegian, and Danish twins showed surprisingly similar results to the studies summarized by Gottesman and Shields: there were higher rates of schizophrenia concordance in monozygotic twins as

compared with the same-sex dizygotic twins.

This trend among studies (higher rates of schizophrenia concordance in monozygotic twins), rather than the specific strengths and limitations of any individual study gives credence to the genetic-transmission hypothesis.

Adoption Studies. Adoption studies have been analyzed from many perspectives: adoptees who became schizophrenic, adopted-away children of schizophrenic parents, or adoptive parents who later became schizophrenic. In general, these adoptive studies support the hypothesis of a genetic component to schizophrenia transmission because of the results showing a higher rate of schizophrenia from the various researched perspectives.

The studies conducted by Wender, Rosenthal, and Kety et al (1974) were interesting. Their approach studied children who were adopted into homes where one of the adoptive parents later became schizophrenic. Wender concluded that the adoptive schizophrenic parent had no identifiable schizophrenogenic influence on the adopted child. This conclusion strengthens the genetic implication of schizophrenia causation and makes it inconsistent with a [illegible] environmental cause.

Family History and Family Studies. The studies conducted have been controversial. Baron and coworkers (1985) and Kendler and Associates (1985) found a higher rate of schizophrenia in relatives of schizophrenics. However, Pope and coworkers (1982) found similar schizophrenia rates in family members of patients and controls. It seems that the lack of control over environmental factors makes it difficult to distinguish between genetic and environmental influences.

Biologic Markers. If nothing else, the shift toward biological models has helped to dispel the notion that schizophrenia springs solely from "a combination of personal weakness and poor family life," says Laurie M. Flynn, executive director of the National Alliance for the Mentally Ill (Scientific American). Physical and chemical changes found in the brain have largely discredited beliefs that environment, attachment, family interactions, or stress cause schizophrenia (Taylor, 1987). Persons with schizophrenia may undergo both structural and functional neurological changes, but how these abnormalities occur remains largely a mystery.

The search continues for the "schizophrenia gene", but such a genetic marker has not been found

Researchers have also scrutinized the brains of schizophrenics for signs of abnormality through the use of CAT, MRI, rCBF, PET, and BEAM scans. These scans found evidence of structural and functional brain pathology in schizophrenic patients, but these could not be specifically correlated with schizophrenia. Therefore, the research concludes that no biologic marker has been found that is either sensitive or specific for schizophrenia.

Environmental Research

The family has also been blamed for the illness, schizophrenia. Studies have been conducted to determine how family experience sustains, augments, or causes schizophrenia (Scheflen, 1981). In the study conducted in Puerto Rico (1964), the findings did not indicate that childhood and adolescent experiences caused the illness, but at a particular period in the life of a schizophrenic person, problems produced the exacerbation of schizophrenic symptoms.

Walker et al (1989) concluded that parental psychiatric status and maltreatment showed increases in behavior problems over time for the maltreated children. This study gives support to the supposition that family experiences contribute to the cause of schizophrenia.

Studies on the concept of expressed emotion (EE) also implies that the kind of emotional involvement significantly effects the illness, schizophrenia; especially in schizophrenia relapse. However, when other variables were studied along with the EE index Parker and Johnson (1987) and MacMillan et al (1987) did not find an independent EE effect on outcome. Differences in design, methodology, and interpretation of the studies may explain the discrepant results in the research.

The strongest evidence of a causal role for EE comes from family treatment studies. It seems that families who have participated in these psychoeducational programs have learned constructive ways of communicating with a schizophrenic family member are better able to cope with the illness (Goldstein et al, 1978; Falloon et al, 1982; Leff et al, 1982; Boyd et al, 1985; Kuipers et al, 1985; Hogarty et al, 1986; Tarrier et al, 1988).

EE research has been criticized as an instrument for labeling a family "good", or "bad." Perhaps the best defense for this allegation would be the purpose of EE research: to give a clearer understanding of a still mysterious illness. Blame, should not be an issue, finding the cause(s) of schizophrenia should be

of Excessive Interdependency, Theory of Homeostasis and Stalemate, and the Double-Bind Theory are various methods of familial communication and would require more research conducted to give credence to these theories.

Biochemical Research

The center of attention of the biochemical theory has been the neurotransmitter dopamine. Studies have shown that excess levels of dopamine produce symptoms that resemble schizophrenia. For this reason, many researchers suspect that an excess of dopamine is one of the causes of schizophrenia. The biochemical theory of schizophrenia may describe what is wrong in the brain, but not how it got to be wrong. The structural and functional evidence of brain dysfunction is compatible with the theory of biochemical defects. The tendency for schizophrenia to run in families could be explained by a genetic transmission of the biochemical abnormality.

Researchers still cling to the assumption that three factors together may contribute to schizophrenia: the genetic makeup of an individual, environmental and family experiences of an individual and the biochemical imbalance in an individual (Johnson, 1980).

the issue.

Research has also studied communication deviance (CD) of families. Torrey (1988) states that communication with a schizophrenic should be brief, concise, and unambiguous. Therefore, it is logical that a schizophrenic would have tremendous difficulty functioning in an environment with low levels of communication clarity and accuracy.

Asarnow, Goldstein, and Ben-Meir (1988) conducted a study on CD and their results indicated strong associations between childhood onset schizophrenia spectrum disorders and parental communication deviance. Their data also indicated that CD is not specific to schizophrenia spectrum disorders.

A limitation of this study had an interesting slant: was CD prominent before childhood onset schizophrenia, or become prominent after the illness. The study did not reach a conclusion on this aspect. It is much like the scenario, "Which came first, the chicken or the egg?" Researchers may ask a similar question with schizophrenia: "Which happened first: a family was dysfunctional before the illness started, or the family became dysfunctional after the illness started?"

The other theories of familial causations, Theory

of Excessive Interdependency, Theory of Homeostasis and Stalemate, and the Double-Bind Theory are various methods of familial communication and would require more research conducted to give credence to these theories.

Biochemical Research

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Researchers still cling to the assumption that three factors together may contribute to schizophrenia: the genetic makeup of an individual, environmental and family experiences of an individual and the biochemical imbalance in an individual (Johnson, 1989).

The question, "What causes schizophrenia?," remains unanswered. There are numerous theories, but none have definitely found the causative factor(s). Finding the cause for schizophrenia may help the family cope more effectively, and may lessen their feelings of blame and guilt they have experienced. This reason alone is sufficient for research to continue.

The next section discusses obstacles encountered by families with a schizophrenic member.

Obstacles Encountered By Families

Researchers are now considering the impact a schizophrenic member has on the family. Deinstitutionalization has brought the needs and problems of the family to the forefront. Studies on the stress of living with a schizophrenic family member is sparse, but of the studies conducted there are commonalities (Lefley, 1989; Black et al, 1985; Lefley, 1987; Goldman, 1982; Bernheim, 1989; Taylor, 1987; Torrey, 1988).

The problems faced by families with a schizophrenic member may be placed in the categories of objective and subjective.

Objective: The problems encountered under this category are numerous. The problems sited by the

above researchers are:

1. Financial hardships from medical bills and economic dependency.

2. Issue of where the schizophrenic member should live.

3. The disruption of the household functioning (curtailment of social activities, time commitments that may lead to neglect of others in the family), and altered relationships with friends.

4. Issue of how much responsibility the schizophrenic should have.

5. Learning to cope with the illness and recognize the symptoms of relapse.

6. Balancing the needs of well members as well as the needs of the ill member.

7. Coping with the use of nicotine, caffeine, and other substance usage by the schizophrenic member.

8. Management of aggressive and violent behavior.

Subjective. The subjective category includes internal stress that comes from managing a schizophrenic family member on a twenty-four hour basis. The family may suffer emotional, marital, and health problems as a result. Families have the additional worry of what will happen to the schizophrenic when the principal caregiver is gone

(Lefley, 1987).

The next section addresses coping strategies that families utilize when dealing with a schizophrenic member.

Coping Strategies For Families

The ability to cope with the situation of having a schizophrenic family member seems to be the optimum level for which the family strives. Studies have shown that innovative community-based programs do not reduce family burden substantially (Endicott et al, 1978; Stein, Test, 1980).

Coping strategies for families are generally incorporated in the various treatment options. Research stipulates that developing the right attitude is the single most important thing a family can do to survive schizophrenia (Torrey, 1988). Torrey goes on to say that blame and shame are obstacles that must be overcome in order for the right attitude to evolve.

As stated earlier, coping strategies are addressed in many treatment programs in which families participate. The treatment program must be one that will meet the family's needs, enable them to find answers for the problems they encounter, and enjoy family life of an optimal level.

The next section discusses treatment options that

offer viable solutions to families, and the schizophrenic member

Treatment Options For Families

Deinstitutionalization brought family care of the schizophrenic and the family unit into the public eye. Researchers began investigating the needs of the families and found that knowledge, skills, and group support were essential (Boyd, 1983).

The psychoeducational programs help families enhance their objectivity, develop reasonable expectations for the schizophrenic member, and address their own family needs (Carpenter, 1986).

The various psychoeducational programs have the following commonalities:

Knowledge. The family is educated about schizophrenia: what the symptoms of the illness are; how the schizophrenic perceives the world; the overall system of mental health care for persons with schizophrenia.

Skills. The family will be taught more effective communication skills, coping skills, learn correct avenues for ventilation of feelings, and better management of their home lives.

Group Support. In a support group, families feel the bond of others experiencing similar stress.

acquire desensitization, and normalization about the issue of schizophrenia in the family. These groups also provide on-going support for families and relief from the strains of caring for the schizophrenic member.

With an understanding of the disorder and of their roles in the treatment process, families may provide a more stable home environment for themselves and the schizophrenic family member. The support group can strengthen families and foster the cohesiveness necessary for families to continue forward as a unit.

The next section discusses counselor and family interaction dynamics and how treatment is influenced.

Counselor Variables That Influence Treatment

The counselor can provide substantial help in the treatment process. Surveys have indicated general dissatisfaction with the delivery system and the counselor can do many things to correct this situation (Hatfield, 1982; Holden & Lewine, 1982; Unger & Anthony, 1984).

1. The mental health professional must be knowledgeable of issues of concern to families and of challenges of practical living with a schizophrenic member.

2. The mental health professional must see that needed services are provided for family members themselves.

3. The mental health professional must include the family in the treatment planning. Hatfield (1979) stated that a team approach by professionals and families is needed for the care of the schizophrenic as well as for the reduction of the burden on families.

Chapter three was designed to provide an interpretation and analysis of the data in chapter two. Chapter four will use the interpretive findings of chapter three to answer the research questions. Recommendations and guidelines to foster maximum family growth will be included.

CHAPTER FOUR

Summary, Conclusions, and Recommendations

This paper has been presented in a sequence beginning with Chapter one which presented the problem, need and purpose for the paper on schizophrenia, and its impact from the family's perspective. Chapter two presented the research compiled on the topic, schizophrenia and the family. Chapter three offered an analysis, and interpretation of the data collected in chapter two. Chapter four will use the interpretive findings of chapter three to answer the research questions. Each question will be listed followed by an answer to the question. Recommendations and guidelines to foster maximum family growth will be included to enable the family to better deal with the issues encountered. A summary of Chapter two and Chapter three will allow review of sited information prior to reading the research questions and answers.

The exact cause of schizophrenia remains a mystery. Researchers continue to search for a causative factor so schizophrenia can be prevented in the future. Researchers still cling to the assumption that three factors together may contribute to schizophrenia: the genetic makeup of an individual,

environmental and family experiences of an individual, and the biochemical imbalance in an individual (Johnson, 1989).

Deinstitutionalization brought the focus of treatment on the family because of the impact a schizophrenic member has on the family. The objective and subjective problems encountered may cause emotional, marital and health problems for the family.

Since researchers do not have a cure for schizophrenia, and since many families are caring for their schizophrenic member, coping strategies seem to be the key for lessening stress within the family. The right attitude was sited by Torrey (1988) as crucial in the coping process. He also said that blame and guilt must be overcome in order for the right attitude to develop.

Coping strategies were also addressed in the treatment programs. Research indicates that the psychoeducational approach better meets a family's needs. Carpenter (1986) stipulates that the psychoeducational programs help families enhance their objectivity, develop reasonable expectations for the schizophrenic member, and address their own family needs. Knowledge, skills, and group support were three commonalities of the psychoeducational

approaches.

Surveys indicated a general dissatisfaction with the delivery system and offered ways that counselors can correct this situation (Hatfield, 1982; Holden & Lewine, 1982; Unger & Anthony, 1984). The points made were: mental health professionals must be knowledgeable of family concerns, must see that needed services are provided for family members themselves, and the family should be included in the treatment process.

The first section of Chapter four addresses the research questions and answers.

Question One

What are the dysfunctional practices of families with a schizophrenic member?

It seems that dysfunctional practices cannot be specifically attributed to a particular type of family. The data previously sited indicates that perhaps a family becomes dysfunctional because of the stress and strain of caring for a schizophrenic family member. There are several variables that unless dealt with, may result in a family becoming dysfunctional.

1. A person with schizophrenia has difficulty understanding multiple directives. According to Torrey (1988), a schizophrenic best understands

directions that are brief, concise, and clear. A family that utilizes unclear verbal and nonverbal communication makes the home environment one of confusion for the schizophrenic. There are several treatment programs that incorporate communication skills as a vital part of the treatment process and may help this problem.

2. Feelings of guilt often hinder a family from coping with schizophrenia. The family often blames themselves for the illness. Torrey (1988) sites blame and guilt as the two biggest obstacles that must be overcome by the family in order for the right attitude to evolve. Understanding the illness will perhaps lessen the guilt and blame that families experience.

3. Another variable that leads to family dysfunction is intrafamilial conflict. The stress and strain from living with a schizophrenic member makes it virtually impossible to escape family conflict. Coping with the ups and downs of the illness takes its toll on a family. One solution may be to identify problematic stressors and try to avoid or eliminate them.

4. Sibling problems are often encountered in a family with a schizophrenic member. The brothers and sisters may not understand the schizophrenic's

behavior, may be fearful, or may have feelings of jealousy because of the time involved with caring for the schizophrenic. Siblings can be an asset if they are able to resolve these problems. NAMI has a support group especially for siblings that can help siblings cope with the schizophrenic member.

5. The family must be very selective of the treatment program chosen. If the program does not meet the family's needs, the family may remain or become a dysfunctional one. The mental health professional can acquaint the family with the available programs.

6. A non-working counselor/client relationship may exacerbate the dysfunction in a family. A team approach offers the advantage of "like" goals and cooperation by both counselor and family. Deinstitutionalization has made it imperative for a counselor/client relationship to be a workable one.

7. Sometimes the family does not accept the fact that a family member is ill. It is hoped that if the illness is ignored it will go away. Prompt diagnosis is extremely important with any illness. Schizophrenia, unfortunately, is not like a twenty-four hour virus. The symptoms persist and treatment is of utmost importance.

8. The lack of knowledge about schizophrenia can lead to dysfunctional practices by the family. It is difficult to help someone if you don't understand them or why they behave as they do.

9. There are specific management skills that help a family cope with a schizophrenic member. If a family does not attain these skills, extreme stress on the family unit may be the result.

The variables listed may all lead to a dysfunctional family. It is difficult to truly understand the stress that families endure unless one has experienced first-hand the dynamics involved in a family with a schizophrenic member. Knowing what leads to a dysfunctional family provides valuable information that can be utilized to correct or improve family dynamics.

Question Two

What are obstacles encountered by families with a schizophrenic member?

Helping a family effectively deal with obstacles is a way counselors can aid the family. Counselors must stay knowledgeable of challenges a family encounters for this reason, thus eliminating being looked upon by the family as yet another obstacle that must be overcome. Several common obstacles

encountered by families were identified.

1. It was found that families often experience feelings of guilt, and blame themselves for the illness. These feelings often inhibit the nurturing of a healthy familial environment. These guilt feelings can be appeased somewhat if a counselor explains schizophrenia, its theorized causes, and does not blame the family for the illness.

2. The family has the decision of where the schizophrenic should live. If the schizophrenic member stays at home then many adjustments must be made to balance the needs of the ill and well family members alike. If a balance is not met, then intrafamilial conflicts may result creating more strain in an already stressful situation.

3. Violence, aggression, and sexual issues also pose problems for the family. Behavioral management skills are taught with the psychoeducational approach and can help the family handle such crises.

4. Caffeine, nicotine, alcohol and street drugs pose a problem for the family because of the effect these substances have on the schizophrenic member. The family should talk with the counselor and the schizophrenic member's doctor about these concerns.

5. The family is confronted with guardianship of

the schizophrenic family member. Worry about what will happen to the family member with schizophrenia after those providing care die creates still another burden for the family to bear. The family must give careful consideration to this issue because they are not around to amend the situation; what's done is done. There are some nonprofit organizations that will accept responsibility for the schizophrenic family member after the death of those that did provide care.

Question Three

What are guidelines that foster maximum family growth?

Torrey (1988) sites the most important ingredient for nurturing family growth is the right attitude. It is very hard to have the right attitude unless you understand schizophrenia. Johnson (1989) said, "With understanding comes power." Understanding is a must for the family of a schizophrenic. The family should separate the illness from the family member. Therefore, not looking at the member as diseased, but rather as a person who is afflicted with an illness that needs treatment. Understanding schizophrenia, and its theorized causes, will enable the family to develop the attitude necessary to cope with the illness.

Torrey (1988) says that the right attitude has four elements and can be called a SAFE attitude: Sense of humor, Acceptance of the illness, Family balance, and Expectations which are realistic.

Sense of humor. The family who retains a sense of humor is more successful in coping with the inevitable ups and downs inherent with schizophrenia. A sense of humor does not mean laughing at a person with this illness, but rather laughing with them.

Acceptance of the illness. The family must acknowledge the illness as real, that it is not likely to just go away, and that it will impose some limitations on the person's abilities. The family must accept things as they are, not as they would like them to be.

Family balance. The family needs an environment that balances the needs of the ill and well members alike. This comes with the realization that the schizophrenic family member does not always come first.

Expectations which are realistic. The family must recognize the person has limited capabilities and the family's expectations must be realistic with the capabilities of the schizophrenic.

Supportive siblings can be a major asset in

helping families cope with schizophrenia. It is not easy being a brother or sister to a person with schizophrenia. A sibling must resolve a lot of conflicting feelings. Despite the problems, siblings can be very helpful to the family unit. Siblings should be included in family discussions of treatment, and financial arrangements because the care of the schizophrenic member may become their responsibility as time passes. There is a Sibling Network which was organized by NAMI to help siblings.

Family support groups. Families with a schizophrenic member need to join a support group. These groups offer a haven for ventilation of feelings, sharing of common experiences which may be deemed as important to the family as the sharing of practical information. Exposure to other families struggling with similar problems helps the family develop coping skills.

Question Four

What kind of programs develop and nurture optimal growth in families with a schizophrenic member?

The research compiled makes it clear that families need to have an active role in the treatment process. This is quite fitting because the family is drastically effected when a schizophrenic member lives

at home.

The type of programs that seem to address the various family needs are the psychoeducational approaches. These approaches have knowledge, skills, and group support components. These three components of a program allow the family and mental health professional to work as a team for the optimal growth of the family unit.

The knowledge component fulfills a need families have to understand the illness, the behavior of the schizophrenic, and understand their feelings about the illness. The skills component assists the family with tasks such as: more effective nonverbal and verbal communication; coping skills for optimum home management of the schizophrenic; creating an environment that balances the needs of ill and well members alike. The group support component is very important in the treatment process. Exposure to other parents struggling with similar issues and problems provides an on-going source of support and normalization about the issue of schizophrenia in the family. A key point is that families need to maintain membership with a support group. Support groups offer an outlet for venting emotions that are taxed by caring for a schizophrenic in a twenty four hour

basis.

Question Five

What counselor related variables would be a viable solution to the problems encountered?

There are several ways in which the counselor can effectively assist the family.

1. The counselor must take time to explain schizophrenia, and its theorized causes which will enable the family to better understand their schizophrenic member.

2. The counselor must keep abreast of concerns and needs of families (challenges families face daily when living with a schizophrenic member).

3. The counselor must acknowledge the need for counseling and therapeutic services for family members themselves and make sure this need is met.

4. Do not foster the belief that the family is to blame for the schizophrenia. Conveying these beliefs leads to an unamicable counselor-client relationship and deepens a family's sense of guilt.

5. The counselor may utilize a team approach for treatment, maintaining complete involvement by the family about treatment planning.

The last section of chapter four offers recommendations and guidelines that will enable the

family to better deal with the issues encountered with schizophrenia.

Recommendations to Foster Maximum Family Growth

Recommendations for the family are:

1. Develop the right attitude toward the schizophrenic family member and the illness; persevere.

2. Strive for a working relationship with the mental health professional.

3. Make a list of questions or concerns you may have to discuss with the counselor.

4. Take an active part in the treatment program; be a part of the "team".

5. Select a treatment program that best meets your family's needs; the psychoeducational approaches seem to be preferred.

6. Maintain participation in a support group.

7. The family should not blame themselves for the illness.

8. Become knowledgeable about schizophrenia. Ask the mental health professional to compile a coping packet for the family to enable a clearer understanding of the illness.

Recommendations for the counselor are:

1. Become knowledgeable of issues and concerns to

families, and obstacles encountered with daily living.

2. Enlist the family as an active partner in the treatment program.

3. Relay information to the family about schizophrenia, its theorized causes, and behavioral management tips for the family's utilization.

4. Do not blame the family for the illness.

5. Be empathic to the family and a good listener to what they have to say.

Summary

The purpose of this paper was to present schizophrenia, and the tremendous impact it has on the family from the family's perspective. The family must understand the illness so the feelings of blame can be resolved. The issue of whether the family was dysfunctional before schizophrenia or became dysfunctional after schizophrenia is important to researchers, but not as important to families. Coping skills are of greater importance to families so they may deal with the many ups and downs inherent with the illness. The family's choice of treatment is extremely important and should be one that best meets the needs of the family. The psychoeducational approaches seem to best fit the various needs encountered by families and encourage maintenance in a

family support group which offers many benefits to families.

The mental health professional should be knowledgeable of family concerns and enlist the family members to be active partners in the treatment program. The mental health professional should not blame the family for the illness, but work for the goal of mutual, maximum family growth.

A coping packet is one example of how the counselor can better equip the family with coping skills for schizophrenia. This packet should explain the illness, treatment options, the various medications and their side effects, and support groups. This kind of information would help the family understand schizophrenia. The burden of dealing with a schizophrenic member on a twenty-four hour basis may not be minimized, but effective coping skills may lessen the stress experienced by the family. A goal of optimum family growth by mental health professionals and the family may be achieved if the recommendations listed previously are practiced by both parties.

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